



## *Minority Health*

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This presentation offers a broad overview of the work related to minority health that the Commonwealth Fund has been engaged in and is developing further. It focuses particularly on a few of the key highlights from a national survey on minority health that the Fund released recently.<sup>1</sup>

First, however, it is important to note that the Fund has an impressive history of recognizing and addressing the health needs of minority Americans. As far back as 1926, with the Fund's rural hospital program, an explicit commitment was made to improve access for black Americans in those rural areas.

Also about that time, in 1930, Edward Harkness, the first President of the Fund, made the first Commonwealth Fund grant. The grant was made to Meharry Medical College, one of the few places to develop a school where minority students could go for health professions training.

Under Miss Mahoney's leadership over the past 14 years, the Fund has maintained a strong focus on the health concerns of minority Americans. This has been primarily through the development of a fellowship for minority medical students in academic medicine, administered by the National Medical Fellowships Program. Continued support has gone to Meharry Medical College, and there has also been support of projects to do further analysis and advance the state of knowledge in terms of health issues facing minority populations.

As earlier presentations at this Symposium have made clear, however, inequities in health care services continue to exist for many minority Americans. These realities strengthen the Fund's

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position on the need for continued focused attention on minority populations. To that end, the Fund supported a national survey on minority health in 1994, both as part of its development of further work in this area, as well as an effort to advance the knowledge on minority health issues.

This presentation highlights a few of the survey's preliminary findings, related particularly with problems in receiving health care services. The survey included over 1,000 blacks, 1,000 Hispanics, 1,000 whites, and over 600 Asian-Americans. It was conducted between May and July of 1994 and was released in March 1995.

One of the important features of the survey was our ability to gather data on such a diverse population at the level and amount of detail that were accomplished. While some generalizations can be made in terms of comparing the health of minority Americans and white Americans, there are also some important differences in the experiences of the different racial and ethnic populations that need to be taken into account.

Overall, our purpose with the survey was to document people's experiences with receiving health care services, as well as barriers they faced in accessing health care services.

In parallel with other national surveys, we found that minority adults were twice as likely to be uninsured as white adults (Fig. 1). Thirty-one percent of minority adults, compared with 14% of white adults, reported having no health insurance at the time of the survey. Of particular note, 38% of Hispanic Americans are uninsured. We also found that minority adults were more likely to have experienced a lapse in their health insurance coverage at some point during the past 2 years.

While the workplace remains the largest source of health insurance overall, we found that minority employees were less likely to have employer-based insurance than were white employees (Fig. 2). Overall, 66% of white employees had employer-based insurance, compared with 56% of minority employees. Once again, the numbers for Hispanic employees stood out: only 50% of Hispanic employees reported receiving insurance through their employer.

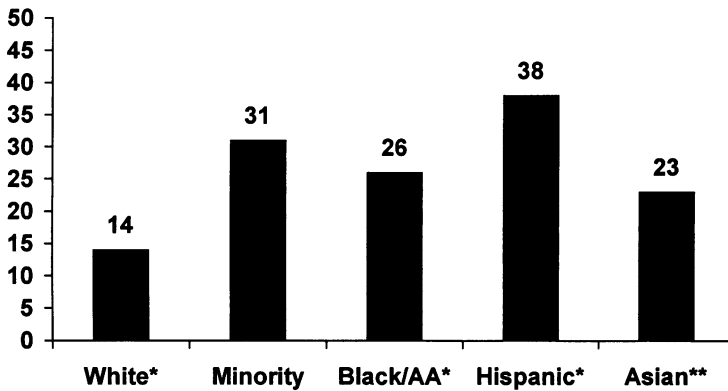


FIG. 1. Percentage of uninsured adults, ages 18–64, by ethnic groups. \*“White” represents non-Hispanic white adults in the United States; “Black/AA” represents black, African-American and Caribbean adults; “Hispanic” represents Mexican, Puerto Rican, Cuban, and other Latino adults. “Minority” refers to all nonwhite respondents, weighted to their true proportion of the population. \*\*“Asian” represents an oversampling of Chinese, Vietnamese, and Korean adults in the United States.

Another important focus for us on the survey was related to patient experiences (Fig. 3). Minority adults reported less choice in where they received their health care services, with 29% of minority adults compared with 16% of white adults reporting very little or no choice. The main reasons given for this limited choice were related to inadequate or no insurance or the high cost of medical care.

We also found that minority adults reported more problems in obtaining care (Fig. 4). Whereas 26% of white adults reported that

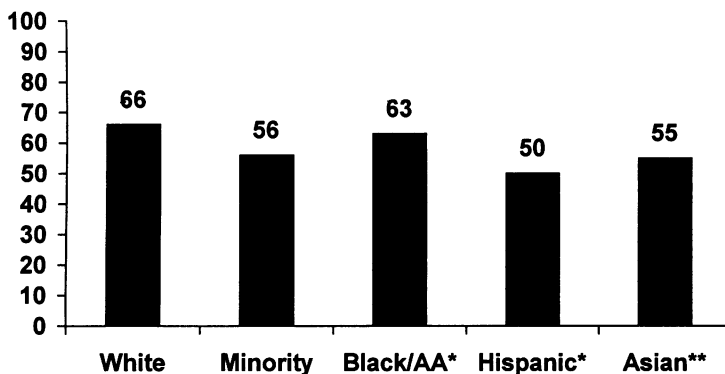


FIG. 2. Percentage of employees, ages 18–64, having employer-based insurance. (\*; \*\*, see legend for FIG. 1.)

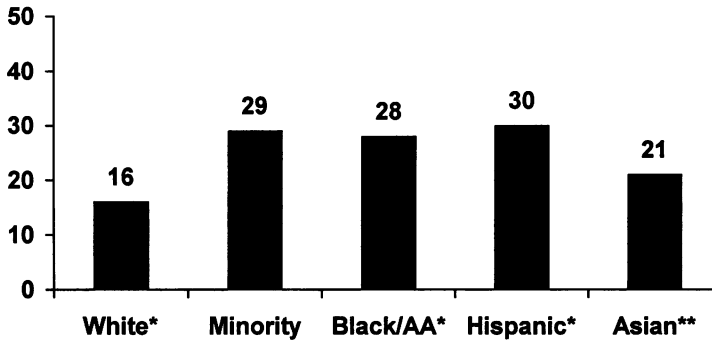


FIG. 3. Percentage of adults reporting "very little choice" or "no choice" in where they received health care. (\*; \*\*, see legend for FIG. 1.)

having to pay for care was a major problem, 35% of African-Americans, 45% of Hispanic-Americans, and 41% of Asian-Americans had great difficulty paying for their care. We also found that minority adults were more likely to say that they had postponed seeking care.

Getting specialty care was reported as a major problem for many minority adults (Fig. 5). Eighteen percent of minority adults, compared with 8% of white adults, said that access to specialty care was a major problem for them. Analyzed by ethnic groups, this finding ranged from 16% of African-Americans, 22% of Hispanic-Americans, and 25% among Asian-Americans. It was particularly noted that this was one of the areas where, along with

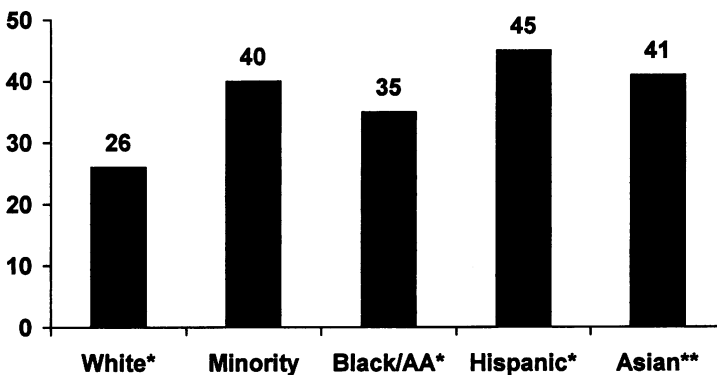


FIG. 4. Percentage of adults reporting that paying for medical care is a "major problem." (\*; \*\*, see legend for FIG. 1.)

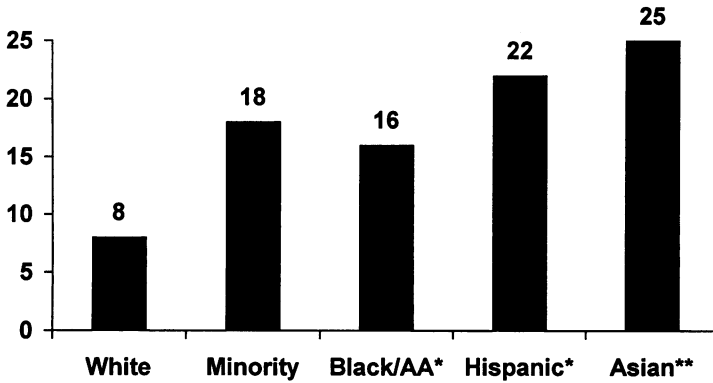


FIG. 5. Percentage of adults reporting a "major problem" with accessing specialty care. (\*; \*\*, see legend for FIG. 1.)

difficulties related to language barriers, Asian-Americans have great problems in accessing health care services.

We also found that satisfaction with health care was reported to be less among minority adults (Fig. 6). Forty-six percent of minority adults, in contrast to 60% of white adults, were very satisfied with their care. Minority adults were also less likely to be satisfied with their physicians, with the helpfulness of the office staff in their doctors' offices, and overall were less likely to feel very welcome at their doctors' offices.

While we found that receipt of preventive care was reported at about a comparable level for white and African-American adults,

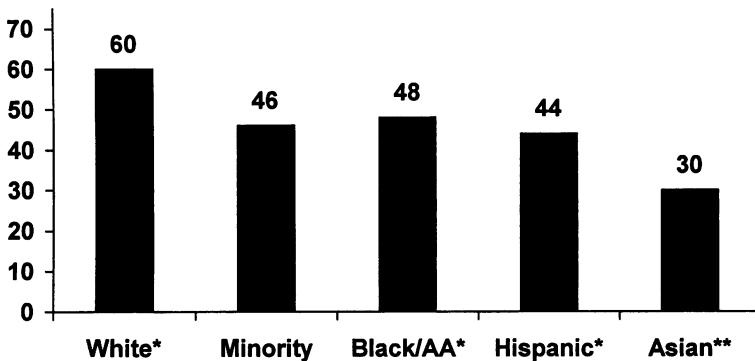


FIG. 6. Percentage of adults reporting themselves "very satisfied" with the quality of their care. (\*; \*\*, see legend for FIG. 1.)

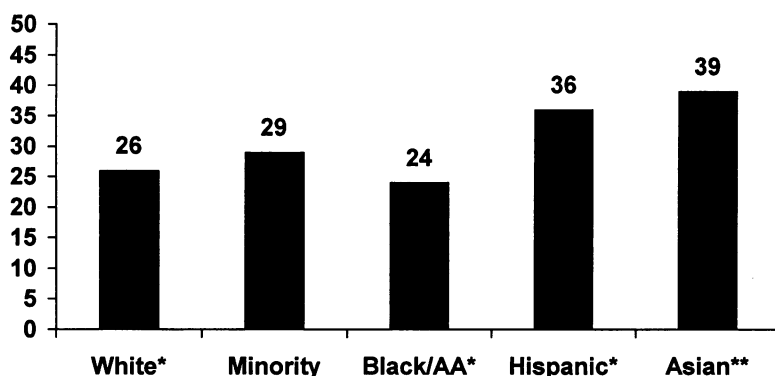


FIG. 7. Percentage of adults not receiving preventive care (Base = persons visiting a physician in the previous 12 months). (\*; \*\*, see legend for FIG. 1.)

nearly 40% of Hispanic and Asian-Americans reported not receiving any preventive care in the last year (Fig. 7).

We were disturbed to find that among some portion of each of the racial or ethnic minority groups, there was a feeling that they would have received better care if they had been of a different race (Fig. 8). Nineteen percent of African-Americans, 14% of Hispanics, and 8% of Asian-Americans responded this way.

Given the disparities demonstrated in these findings, as well as the work of many other researchers, the Fund thinks that it is particularly critical at this time to continue to focus on the experiences of minority Americans. Rapid changes in the way health care is financed and delivered, incentives to limit cost, incentives to

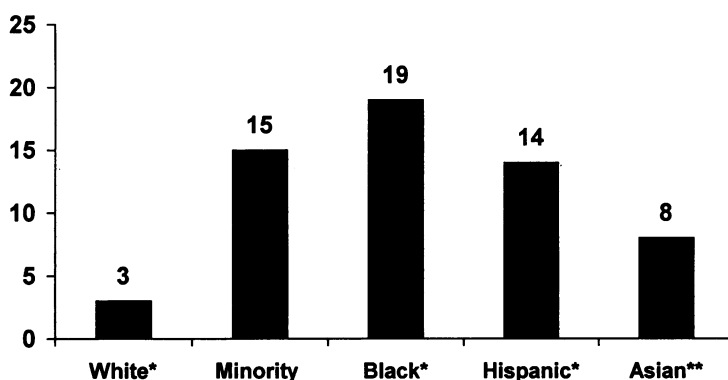


FIG. 8. Percentage of adults reporting a belief that their quality of care is less because of ethnicity. (\*; \*\*, see legend for FIG. 1.)

provide fewer services, and limited public funding, all place the populations that have historically been underserved at even greater risk. The Fund thinks that the impact of these changes requires continued monitoring and assessment with respect to policy initiatives.

The Fund, therefore, is developing two new programs in minority health. The first will be managed care in minority communities. That program will have the overall goals of developing timely information about the impact of changes in health care on minority communities, including the availability and quality of care, particularly under Medicaid managed care; assessing the impact on providers who have traditionally served in minority, low-income communities; and finally, assessing the availability and the trends in available care for those without insurance.

The second program, which is in the planning phase, is a minority health policy fellowship program. This endeavor will have the goal of expanding minority physician leadership in health policy. We anticipate that the first class of fellows will begin in summer, 1996.

With both these programs, the Fund's overall goal will be maintaining a focus on underserved populations in ways that are relevant to the current environment with respect to changes in health care services.

### *Reference*

1. The Commonwealth Fund. *National Comparative Survey of Minority Health Care*. Louis Harris and Associates, 1994.